2002

Iatrogenic Symptoms in Psychotherapy

Charles W. Boisvert
Rhode Island College, cboisvert@ric.edi

David Faust
University of Rhode Island

Citation

Boisvert, C. M., & Faust, D. (2002). Iatrogenic symptoms in Psychotherapy: A theoretical exploration of the potential impact of labels, language, and belief systems. *American Journal Of Psychotherapy, 56*(2), 244-259.

Iatrogenic Symptoms in Psychotherapy

A Theoretical Exploration of the Potential Impact of Labels, Language, and Belief Systems

CHARLES M. BOISVERT, Ph.D.*
DAVID FAUST, Ph.D.**

Although the mental health professions are effective in ameliorating personal distress, treatment can sometimes have negative consequences. The authors explore causal mechanisms for iatrogenic symptoms in therapy by discussing the processes by which clients may be socialized into therapy and the potential impact that psychiatric labels and language may have in influencing clients' self-perceptions. The authors review research that has examined possible negative effects of psychiatric labels and then examine other forms of language, categorization, and conceptualizations that may contribute to negative effects in therapy. Iatrogenic symptoms may originate through the overreliance on a belief system within which therapists interpret, reinterpret, or label clients' characteristics or distress as pathological. Therapeutic communication that emphasizes pejorative language may introduce clients to this belief system. Iatrogenic symptoms may also provide clients and therapists with secondary gains. Possible approaches for minimizing iatrogenic symptoms are explored.

The core mental health professions—psychiatric nursing, psychiatry, psychology, and social work—embrace noble intentions, namely, to understand, predict, and alter behavior such that individuals, societies, and cultures will achieve greater well-being. However, acts of healing and associated treatments inevitably have not only curative, but also unwanted effects (1). Although the mental health professions serve a salutary function, they are not immune to deleterious or iatrogenic effects. We explore causal mechanisms for iatrogenic symptoms by discussing the processes through which clients are socialized into therapy and the potential impact of psychiatric language and belief systems in influencing clients' self-perceptions. We conclude with suggestions for reducing iatrogenic symp-

*Assistant Professor, Department of Counseling and Educational Psychology, Rhode Island College. ***Mailing address***: Department of Counseling and Educational Psychology, Rhode Island College, 600 Mt. Pleasant Ave. Providence, RI 02908, cboisvert@ric.edu.
**Professor, Department of Psychology, University of Rhode Island.

Bazilian (16) suggests that professionals may have difficulty recognizing negative treatment effects. For example, a therapist may misattribute a client's behavior to a disorder (e.g., it was the client's symptoms of schizophrenia that caused the client's distress) rather than to the treatment (e.g., the therapy that caused the client's distress by exploring emotionally laden issues). Given the absence of a counterfactual, or knowledge of what would have happened had one done otherwise (e.g., not treated or treated differently), it can be difficult to properly decipher both positive and negative treatment effects (17). A patient who does well may have done better without the treatment, and a patient who does poorly might have fared much worse without the treatment. Given what seems to be limited attention to negative treatment effects in the literature and difficulty detecting such occurrences, it is certainly possible that Bazilian is correct. Of interest, in a survey of attitudes toward the treatment of children, parents were more concerned than therapists about possible iatrogenic symptoms (18).

In a national survey, therapists rated the extent to which research supported a number of assertions about psychotherapy outcome. The majority of respondents were either incorrect about research findings on iatrogenic effects (i.e., they tended to underestimate the frequency of negative treatment outcomes) or simply indicated that they were unaware of research in this area (Boisvert, 1999, unpublished doctoral dissertation).

Causal Mechanisms

Research has not yet provided a clear understanding of the mechanisms by which iatrogenic effects occur, although several explanations have been proposed. Possible explanations include clients misinterpreting transference or concluding therapy with unresolved transference (1, 16, 19) and errors in therapy technique (11). Additionally, Campbell (20) suggested that therapists have a tendency to draw negative inferences about clients' support systems and to subsequently overvalue the therapy relationship. This may further add to clients' distress by breaking down or minimizing the curative potential in clients' support systems. Lambert and Bergin (8) suggested that negative treatment effects may partly result from "therapeutic techniques that are aimed at breaking down, challenging, or undermining habitual coping strategies or defenses" (p. 176). Zuckerman (21) suggested that time restrictions imposed in therapy by third parties, such as managed care, can lead to iatrogenic effects by altering the therapeutic process and compromising the therapeutic relationship.

Bazilian (16) suggests that professionals may have difficulty recognizing negative treatment effects. For example, a therapist may misattribute a client's behavior to a disorder (e.g., it was the client's symptoms of schizophrenia that caused the client's distress) rather than to the treatment (e.g., the therapy that caused the client's distress by exploring emotionally laden issues). Given the absence of a counterfactual, or knowledge of what would have happened had one done otherwise (e.g., not treated or treated differently), it can be difficult to properly decipher both positive and negative treatment effects (17). A patient who does well may have done better without the treatment, and a patient who does poorly might have fared much worse without the treatment. Given what seems to be limited attention to negative treatment effects in the literature and difficulty detecting such occurrences, it is certainly possible that Bazilian is correct. Of interest, in a survey of attitudes toward the treatment of children, parents were more concerned than therapists about possible iatrogenic symptoms (18).

In a national survey, therapists rated the extent to which research supported a number of assertions about psychotherapy outcome. The majority of respondents were either incorrect about research findings on iatrogenic effects (i.e., they tended to underestimate the frequency of negative treatment outcomes) or simply indicated that they were unaware of research in this area (Boisvert, 1999, unpublished doctoral dissertation).

Causal Mechanisms

Research has not yet provided a clear understanding of the mechanisms by which iatrogenic effects occur, although several explanations have been proposed. Possible explanations include clients misinterpreting transference or concluding therapy with unresolved transference (1, 16, 19) and errors in therapy technique (11). Additionally, Campbell (20) suggested that therapists have a tendency to draw negative inferences about clients' support systems and to subsequently overvalue the therapy relationship. This may further add to clients' distress by breaking down or minimizing the curative potential in clients' support systems. Lambert and Bergin (8) suggested that negative treatment effects may partly result from "therapeutic techniques that are aimed at breaking down, challenging, or undermining habitual coping strategies or defenses" (p. 176). Zuckerman (21) suggested that time restrictions imposed in therapy by third parties, such as managed care, can lead to iatrogenic effects by altering the therapeutic process and compromising the therapeutic relationship.

toms. Many of the ideas we offer are generalizations, which require further formal investigation, and any one idea may or may not apply to a particular therapist. In general, we hope to raise therapists' awareness of the complex process of therapy and its potential to produce undesirable effects. We also hope to encourage further research and discussion in an area that seemingly has been given little attention in the literature.

IATROGENIC SYMPTOMS

Definition

The American Psychiatric Association defines iatrogenic illness as "a disorder precipitated, aggravated, or induced by the physician's attitude, examination, comments, or treatment" (2, p. 103). Although iatrogenic symptoms have often been associated with medication side effects (3, 4) or other forms of medical treatment (5), research shows that iatrogenic symptoms can result from other treatments, e.g., psychotherapy (6–11).

Treatment Outcomes: The Co-occurrence of Positive and Negative Effects

It would be utopian to believe that *therapy with any particular patient* produces effects that are *exclusively* positive. Mental health treatment is likely to produce some degree or type of negative effects as well. For example, a client may experience increased self-esteem and assertiveness after therapy, but feel less positive about family members and experience less acceptance from others who now feel threatened by the client's behavioral changes. Fortunately, in the majority of cases, positive treatment effects far outweigh negative effects (8, 12, 13). Research, however, shows that cases in which negative results predominate may not be that uncommon (8, 10, 14). Research finds that therapy leads to negative consequences for a considerable number of clients, perhaps about 10% (8, 10). This is a sobering statistic considering the number of people who receive therapy (15).

A fundamental goal of treatment is to shift the balance of positive and negative effects in an increasingly favorable direction, or to maximize benefits and minimize harm. Completely eliminating any negative treatment effects is unrealistic and perhaps only accomplished by ceasing all treatment, which, given the overall positive balance of treatment outcomes, would ultimately do considerably greater harm than good. Although we naturally tend to be more concerned about avoiding extremely negative outcomes (e.g., a client develops a severe depression as a result of treatment), virtually every client, even those with predominantly positive outcomes, benefits when negative effects are reduced.

PATHOLOGY-ORIENTED BELIEF SYSTEMS: A SUBTLE MECHANISM FOR IATROGENIC EFFECTS

In the following pages, we will explore potential mechanisms for iatrogenic effects, as a whole, which seemingly have been given less attention in the literature. Specifically, iatrogenic symptoms may originate from a pathology-oriented belief system through which therapists interpret, reinterpret, or label clients' personal characteristics, life script, or distress. Clients may be socialized into therapy through a language system that emphasizes pejorative labels and suggests that therapists hold specialized knowledge that, in truth, they may or may not possess. Therapists may give clients the implicit or explicit message that something is wrong or flawed with them, which, in turn, may contribute to negative treatment effects.

Making Initial Formulations

At the outset of therapy, some formulation is generally reached about the client's status, the client's suitability for treatment, and his/her treatment needs. An individual, who seeks therapy, usually starts off with the belief that a problem exists. The client then enters into a dialogue with the therapist who indicates whether or not the client has a problem requiring treatment and what treatment is required. One can conceptualize the ideal outcome of the exchange as one in which the client's and the therapist's opinions are congruent with each other and with "reality" (e.g., the client truly does have a problem, and the client and therapist agree that a problem does exist). Also, an implicit message may be conveyed that, absent the treatment, the problem may not (or will not) resolve itself and is likely to get worse. At times, of course, such beliefs may be very well justified. However, at other times, the therapist may see more disorder than is present and consequently persuade clients of the same belief.

Once the client has agreed to proceed with therapy, problem areas are further clarified to assist the client in identifying treatment goals. As such, clients may experience increased distress as problems are discussed. In particular, during the initial phase, therapists may not only identify problem areas, but may seemingly, by necessity, point out negative consequences that clients may experience if they go untreated. This may be used to reduce the client's resistance to treatment or to increase motivation. An implicit assumption is that the therapy will continue on to "completion," and the client will be "cured" or the problem substantially reduced. However, if the client attends fewer sessions than anticipated or prematurely terminates, which occurs in a substantial percentage of cases,

(22), then the client may be harmed, especially if she has "overinterpreted" any negative messages or pejorative language.

Introducing Clients to a New Belief System

In presenting their case formulations, therapists may encourage clients to accept a "new system" of viewing behavior. Therapists may introduce a belief system which suggests that they know more than the client, and possibly even more than the client knows about him/herself. At times, therapists' case formulations may lead to the impression of greater knowledge than actually exists.

Some therapists commonly espouse belief systems that incorporate various assumptions about the nature and cause of human suffering, and treatments to alleviate such suffering. Clients, many of whom are acutely distressed when they seek treatment, may be unduly vulnerable and unconditionally accept the tacit assumptions within this belief system. Some therapists may also hold a deep commitment to the implicit and explicit assumptions of their belief system and overlook alternative views, views that clients may endorse but that may contradict the therapist's beliefs. As a result, clients may feel flawed, damaged, and inferior and may consequently experience increased anxiety or distress.

There are various ways that therapists may introduce clients to a "new system" for understanding their behavior. For example, therapists may use nonverbal cues (e.g., head shakes and eye contact) to reinforce formulations or interpretations that are syntonic with the therapist's beliefs regarding the cause of clients' distress. Therapists may also interpret and reinterpret clients' behavior within a "pathology-oriented" framework, and use "pathological language" to communicate, explain, or create this framework.

To summarize thus far, at some point in the therapeutic encounter, clients may well emerge with a diagnostic label, formal or otherwise, and a set of assumptions about their condition, the therapist, and the treatment. These assumptions may lead to various negative consequences. Next, with this in mind, we review research that has examined the effects of psychiatric labels and then consider other forms of language, categorization, and conceptualization that may contribute to negative treatment effects.

DSM AND PSYCHIATRIC LABELS

Since its inception in 1952, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) has attempted to identify and describe mental disorders.

What has ensued is a lengthy list of psychiatric conditions representing anything from "Coordination Disorder" to "Undifferentiated Schizophrenia." The DSM taxonomy, representing putative categories that demarcate boundaries between normality and abnormality, seems to be wide-ranging, making efforts to describe many supposed human aberrations.

Psychiatric labels can influence perception powerfully. Categorization or labeling can assist in understanding and organizing phenomena in our complex social world, convey information in a simplified manner, and aid in making predictions. Additionally, psychiatric labels may assist in understanding the causes of behavior, facilitate communication among professionals, and provide a framework through which behavior can be described, explained, and treated.

However, to the extent that psychiatric labels facilitate understanding of behavior, they also have the potential to bias judgment. The DSM conceptualizes psychiatric conditions through evoking a language characterized by disease metaphors, suggesting that these conditions are manifestations, at least in part, of some sort of internal pathology. As such, professionals may potentially embrace an ideology that delimits understanding of rich human experiences, in part by being too quick to interpret them as "diseases" residing indelibly within the person.

Research shows that therapists may too readily make personality attributions about the cause of problems if the client is described as chronic (23) or if the therapist has access to a preexisting diagnosis (24). Other studies have found that certain theoretical orientations may lead to overpathologizing, such as overattributing greater maladjustment to persons with a psychiatric label compared to those without the label (25, 26).

According to Batson, O'Quin, and Pych (27), therapists may exhibit dispositional biases toward their clients for several reasons. Therapists tend to focus on the client rather than on the situation, see the client only in a clinical setting, and work from a model that casts symptoms and problems as entities residing within the person. Furman and Ahola (28) indicated that professionals' causal attributions of their clients' behavior may have profound effects on treatment responses and lead to negative outcomes. For example, attributing a client's behavior to "psychopathology" rather than to "family problems" may negatively impact the client's self-esteem and increase feelings of depression.

Research has also suggested that psychiatric labels can contribute to negative self-perceptions and stereotyping (29–35), jeopardize social acceptance (32, 36–38), and generate negative attitudes in the public (39).

Our position is certainly not antinosological. We believe that scientif-

ically sound categories can be of great assistance, that some currently defined psychiatric disorders have begun to "carve nature at the joints," and that some categories have at least a partial physical basis, cause, or referent. Thus, our concern is not with labeling or diagnosing per se, but with limitations and potential problems in current use. Psychiatric categories are often overextended and many are still very tentative conceptualizations. Additionally, we believe that categories cannot capture many aspects of human experience and that there is still much work to be done in developing a scientifically sound diagnostic system.

If, as research shows, the language of labeling can exert negative influences, it is but a small inferential step to posit that other forms of psychiatric language and conceptualization can exert positive and negative effects as well. For example, other categories, such as descriptors that are not part of a taxon (e.g., ACOA), as well as concepts, metaphors, and explanations, may also lead to negative effects. Although psychiatric language may be a product largely of our professional belief system and reflect the assumptions therein, this same language and its associated conceptualizations may perpetuate this view and further shape both therapists' and clients' perceptions. It may be that the language itself serves to construct or reconstruct a new self and worldview for the client. Next, we explore the mechanisms by which iatrogenic effects may be created through the language that characterizes our belief system, and how this language may shape socially sanctioned roles in therapy.

LANGUAGE AND METAPHORS: A SUBTLE MECHANISM FOR IATROGENIC SYMPTOMS

The mental health field is replete with psychiatric jargon and talk (e.g., "I think she's an *ACOA*." "Sounds like *Axis II stuff*." "He's an *enabler*." "She's playing the *dependency* role again." "Don't *feed into* his behavior"). Such psychiatric jargon and associated metaphorical language may catalyze positive change. For example, informing a client that she is "carrying a lot of baggage" may stimulate certain images of burdens, responsibilities, and unnecessary weight, which may help her to understand her situation better and redefine her experiences. The metaphor may describe a client's experiences in a way that preconceived pathological understandings of behavior are diluted, and the experience becomes normalized through the evoked imagery. Metaphors, thus, may promote insight and facilitate change. Furthermore, metaphorical language may provide a transitional vehicle through which clients can better understand their personal struggles and ultimately, temper more effectively life's burdens.

Clients, however, may become "fixed" on the metaphor and define reality rigidly within the metaphor's linguistic boundaries. This may considerably restrict clients' understanding of their experiences and cause them to pathologize their behavior. For example, the client who learns that she is "carrying a lot of baggage" may subsequently feel vulnerable, victimized, and indefinitely debilitated by such toilsome and oppressive burdens. Clients may literalize the metaphor such that it permanently transforms their self and world perceptions into fixed views (40). Evoking psychiatric labels and suggestive language may sometimes inadvertently lead therapists to believe falsely that they have captured the essence of the client and truly understand complicated clinical phenomena, as well as the worldview of the client.

Psychiatric Language: Sometimes Pathologizing Ordinary Human Experience

Categories and associated descriptors sometimes lead to incorporating nonrelated phenomena under the category. That is, the category or descriptor may provide a framework for therapists to view *most* behavior of the person as "pathological." This may occur even if the behavior has little or no relationship to the descriptor. The psychiatric descriptor may also lead therapists to redefine clients' normal experience as abnormal or to interpret universal human experiences as "pathological" and, in turn, may encourage clients to do the same. Of interest, Logue, Sher and Frensch (41) found that both adult children of alcoholics (ACOA) and non-ACOA subjects rated ACOA personality profiles as highly descriptive of self. The authors concluded that the label ACOA may have widespread acceptance due to "Barnum-like" descriptions and that ultimately, the label may lack the specificity to serve diagnostic and treatment purposes. Another example of this powerful phenomenon was demonstrated in Gough's (42) classic study. He found that therapists, who were instructed to fill out the Minnesota Multiphasic Personality Inventory as they thought their clients would, produced grossly inflated elevations on most scales — much greater elevations, in breadth and severity of pathology, than true patients. Thus, in many cases, on items for which patients would have provided unremarkable responses, therapists assumed aberrant beliefs or behaviors. Ultimately, labeling and related tendencies can easily lead therapists to overlook a simple but key point, so aptly stated by Meehl: "If you examine the contents of a mental patient's mind, he will, by and large, have pretty much the same things on his mind as the rest of us do" (43, p. 246).

PSYCHIATRIC LANGUAGE: ALTERING SELF-PERCEPTIONS AND SOCIAL ROLES

Psychiatric language and descriptors may negatively impact clients' self-perceptions and lead them to falsely interpret their behaviors as stemming from some underlying disease. For example, if a client's behavior and experiences are categorized under the descriptor "Self-Defeating Personality" or "Co-Dependency," the client's "window" of normality may be narrowed. Clients may alter their self-perceptions as they subsequently interpret most or all of their experiences as manifestations of the inherent abnormality or "disease process" implicated by the descriptor. Additionally, the descriptor may promote "excuse-making," in that individuals may avoid responsibilities and "justify" their behavior through evoking their "psychiatric condition."

Link (32), and Link, Cullen, Struening, et al. (37) suggested that labeling can alter social attitudes, generate negative consequences, and lead to self-fulfilling prophesies. This occurs through the sociopsychological mechanisms of devaluation and defensiveness that arise from expectations of rejection. Link (32) suggested that labeling can be understood from a sociocultural perspective in which individuals, before they seek treatment, develop beliefs, due to social stereotypes, of how others perceive mental patients. This provides a possible framework for understanding that iatrogenic symptoms may develop through clients developing negative beliefs about "being a mental patient"; in essence, many of the clients' reactions may be normal reactions to the anticipated attitudes that others may have toward them.

Psychiatric language and diagnostic categories may contribute not only to the loss of status, social distance, and the expectation of rejection, but also may generate shame (31, 34). Retzinger (34) explored the concept of secondary deviance as an iatrogenic phenomenon that occurs in response to being labeled and suggested that "unacknowledged shame due to rejection, immediately produces iatrogenic symptoms" (p. 325). The client may experience subsequent interventions as an exposure of personal inadequacies. Also, due to shame, clients may anticipate rejection from others, hesitate to seek them out, and underutilize social supports.

Changes in self-perceptions may lead clients to further redefine their experiences and "act" the role assumed by the descriptor or the psychiatric language. Graziano and Fink (44) suggested that labeling may reinforce clients' beliefs that they are disordered in ways that are not necessarily grounded in reality by sanctioning ". . .adoption of a sick role" (p. 360). Moreover, professionals may unwittingly breed negative reactions in cli-

ents by actively searching for pathology and at least initially encouraging sick-role behavior.

Psychiatric Language: Anchoring Psychopathology and Creating Secondary Gains

Although clients' behavior may be negatively influenced by the expectations that labels and language create, psychiatric descriptors may anchor the clients' behavior, legitimize the condition, and ensure access to treatment. This may bring about a tacit "socially sanctioned agreement," such that now only the therapist can truly "understand" the client and ameliorate his/her suffering. Iatrogenic symptoms may provide clients and therapists with secondary gains that perpetuate potentially negative patterns. By experiencing distress, clients receive attention, and by labeling and treating the distress, therapists feel needed.

Iatrogenic symptoms may be inevitable in some situations, ultimately enabling one to secure treatment. Adler and Hammett (45) provided an intriguing analysis of the placebo effect as a phenomenon in medicine that functions to satisfy universal human needs for group membership and participation in a social system. They suggested that "the sick role provides a socially sanctioned respite while the practitioner fits the symptoms into a coherent, meaningful system, syntonic with prevailing culture" (p. 596). The parallel can be drawn with therapy relationships within the mental health profession. Clients may experience "psychiatric symptoms" that are consistent with self-perceptions and social expectations implicit in the therapy relationship (i.e., clients are or act sick; therapists will treat). To gain a sense of belonging, the client may "settle down to an organized illness" in which his human experiences become transformed into "psychiatrically acceptable" symptoms (34, pp. 329–330).

STRATEGIES TO REDUCE IATROGENIC EFFECTS

The degree and potential range of negative treatment outcomes may not be readily apparent to therapists whose intentions are clearly aimed at ameliorating clients' distress. However, the presence of negative treatment effects are too pervasive (6, 8–10), and the unfortunate consequences that sometimes result from treatment are too powerful to deny or dismiss cavalierly. It seems important for therapists to become aware of the potential for negative treatment effects, consider factors that may contribute to these effects, and try to minimize them (46). The following strategies are tentatively proposed as means to reduce the extent and frequency of iatrogenic treatment effects.

Maximize Clients' Support Systems

Recognizing and identifying the curative potential in clients' natural support systems may reduce negative treatment effects (20). This may further serve to "normalize" many universal human experiences and minimize tendencies for clients and therapists to overvalue the therapy relationship. Also, it may help reduce dependency (an important goal if one is to maximize treatment effects) that can occur during treatment by assisting the client in transitioning back into the world of relationships that exist outside of therapy. Moreover, it may also demystify some of the tacit assumptions of therapy relationships, such as: professionals hold "unique knowledge and abilities" to resolve clients' problems, and clients necessarily need professional treatment to get better. Many problems may resolve on their own or via natural support systems. That is, many other people (e.g., paraprofessionals, family, support groups) may be effective in helping the client or at least greatly supplement the therapy (47–49). Also, should the client's problem recur, there may be a greater chance that the client can handle the problem without professional help if he/she has learned to effectively utilize his/her natural support system.

Conceptualize Each Therapy Session as the Last

Each therapy session could be the last, and as such, therapists can ask what last (and potentially lasting) message might they want to convey to clients during the session. In fact, research suggests that the majority of clients attend few sessions (50) and that the modal number of sessions attended is one (51). Rosenbaum (52) studied single-session visits with 58 outpatient clients. Following the first session, clients were offered a choice between "single-session therapy" or traditional brief therapy. Fifty-eight percent of the clients felt that the single-session therapy was sufficient. It is incumbent upon therapists to be mindful of the possibility that each therapy session may be the last, and to consider the negative consequences that can result when a message, intended to begin the treatment process by emphasizing problems and needs, becomes a final statement that the client perceives as a reinforcement of his/her shortcomings.

Talmon (51, 53) provided some practical suggestions for making the most out of a single therapy session. He suggested that therapists identify and emphasize clients' strengths, abilities, and solutions; reinforce solutions that clients have used in the past to better manage personal problems; encourage homework assignments to motivate clients; reframe problems as a source of hope, self-mastery, and a valuable challenge to change for the better; conceptualize therapy as a chance for clients to reinforce skills and

experience success rather than as a chance to focus on deficits and eliminate problems; and identify clients as the primary agents of change.

Practice New Mental Habits Derived from Decision Theory

Research on human decision making suggests an approach for altering deeply ingrained judgmental habits, or in this case what one might consider our sometimes potentially biased worldview. Arkes (54) suggested that certain judgmental biases can be reduced by considering the opposite, or generating evidence for alternative conclusions. Thus, therapists could invoke the following when formulating a judgment about a client: a) for each time one concludes that a problem requires treatment, one might generate reasons to believe that the problem may resolve on its own or may respond to other approaches (e.g., social supports); b) for each act of classifying a behavior as pathological, one might search for a more normalizing explanation (e.g., an angry outburst may not be due to an impulse-control disorder but to intolerable stress); and c) for each time one feels the need to convince the client about the presence of some negative characteristic, one might point out some less recognized strength or positive attribute, even at the beginning of treatment when initial formulations are being made.

It may also be helpful to consider the possibility (and in some cases the probability) that some clients may simply be in a difficult situation that will resolve itself in time and thus may not require therapy (55), and that the great bulk of a person's essence and life experience is not captured by a psychiatric label and is not related to pathology. Such self-debiasing strategies may reduce tendencies to overpathologize and thereby reduce the potential for negative treatment effects.

Stay Solution-Focused

Although transitory negative treatment effects may be an expectation of the sophisticated therapist (1), the potential negative effects of therapy should be readily discussed, and reexamined in light of the therapy relationship within which behaviors may assume new meanings. Crown (1) recommended implementing a trial period of therapy in which negative treatment effects can be minimized by decreasing the frequency of sessions and the depth of exploration. He supported changing the focus in therapy from in-depth exploration to problem solving, particularly if long-term therapy seems unwarranted.

Solution-Focused Therapy (SFT), which seeks to incorporate client's strengths into the therapy and minimize the focus on deficits, has gained popularity, particularly within family therapy (56–58). Barnard (56) sug-

gested that therapists are often overly attentive to clients' deficits and pathology and therefore overlook strengths. He warns therapists not to become "seduced into the attractive web of 'pathologizing'" (p. 135). SFT ultimately may not only create positive change in clients but may help reduce iatrogenic effects by providing therapists with a framework and approach that defines the client, not by pathology or deficits, but by strengths and capabilities.

CONCLUSION

The mental health professions serve a laudatory role in remediating human suffering and facilitating the resolution of interpersonal difficulties. Although abundant research demonstrates the overall substantive benefit of therapy, therapy will inevitably create some degree of negative effects for virtually all clients. Therapists may be able to reduce the frequency and level of negative effects through reexamining some of the more fundamental aspects of treatment relationships and reconsidering some of the tacit assumptions within the "professional belief system" upon which sanctioned treatment relationships may be constructed.

Traditionally, tremendous attention has been given to approaches for increasing the positive effects of therapy, which is undoubtedly a worthy goal, but too little attention has been directed toward the presence of negative effects and ways of reducing them. We have emphasized the importance of recognizing treatment as a balance of positive and negative outcomes. We understand that some of what we present is speculative and requires formal study to ascertain more clearly the nature and extent of iatrogenic effects. However, we hope to encourage therapists to recognize the potential for iatrogenic effects and maintain an awareness of factors that may contribute to or perpetuate their occurrence. To embrace a treatment philosophy that falls short of this will likely underestimate the potential for, and possibly contribute to the development of, a powerful and often elusive treatment phenomenon. A good starting point may be in increasing our sensitivity to the implicit and explicit messages we may convey to clients, working actively to consider alternative perspectives, and ultimately recognizing the limits of our knowledge.

Acknowledgments: The authors thank Mohiuddin Ahmed, Ph.D., Albert Ellis, Ph.D., William Glasser, M.D., Bruce Link, Ph.D., and Albert Lott, Ph.D., for reviewing an earlier draft of the manuscript.

REFERENCES

1. Crown S (1983). Contraindications and dangers of psychotherapy. *British Journal of Psychiatry, 143*, 436–441.
2. Edgerton JE, Campbell RJ (1994). *American psychiatry glossary* (7th ed.). Washington, DC: American Psychiatric Press, Inc.
3. Meyer JD, Fink CM (1980). Psychiatric symptoms from prescription medications. *Professional Psychology: Research and Practice, 20*, 90–96.
4. Tollefson GD (1990). Fluoxetine and suicidal ideation. *American Journal of Psychiatry, 147*, 1691–1692.
5. Taylor RL (2000). *Distinguishing psychological from organic disorders: Screening for psychological masquerade* (2nd ed.). New York: Springer Publishing Company, Inc.
6. Bergin AE (1980). Negative effects revisited: A reply. *Professional Psychology, 11*, 93–100.
7. Hadley SW, Strupp HH (1976). Contemporary views of negative effects in psychotherapy. *Archives of General Psychiatry, 33*, 1291–1302.
8. Lambert MJ, Bergin AE (1994). The effectiveness of psychotherapy. In A. E. Bergin, S. L. Garfield, (Eds.), *Handbook of Psychotherapy and Behavior Change* (4th ed.) (pp. 143–189). New York: John Wiley & Sons, Inc.
9. Mays DT, Franks CM (1985). *Above all do not harm: Negative outcome in psychotherapy and what to do about it*. New York: Springer.
10. Mohr DC (1995). Negative outcome in psychotherapy: A critical review. *Clinical Psychology: Science and Practice, 2*, 1–27.
11. Sachs JS (1983). Negative factors in brief psychotherapy: An empirical assessment. *Journal of Consulting and Clinical Psychology, 51*, 557–564.
12. Seligman MEP (1995). The effectiveness of psychotherapy: The consumer reports study. *American Psychologist, 48*, 966–971.
13. Smith ML, Glass GV (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32*, 752–760.
14. Strupp HH, Hadley SW, & Gomes-Schwartz B (1977). *Psychotherapy for better or worse: The problem of negative effects*. New York: Jason Aronson, Inc.
15. Olfson M, Pincus HA (1994). Outpatient psychotherapy in the United States, I: Volume, costs, and user characteristics. *American Journal of Psychiatry, 151*, 1281–1288.
16. Bazilian SE (1993). Iatrogenic blocks to therapeutic progress: A study of countertransference resistances. *Modern Psychoanalysis, 18*, 157–178.
17. Mays DT, Franks CM (1980). Getting worse: Psychotherapy or no treatment: The jury should still be out. *Professional Psychology, 11*, 78–92.
18. Jensen JA, McNamara JR, & Gustafson KE (1991). Parents' and clinicians' attitudes toward the risks and benefits of child psychotherapy: A study of informed-consent content. *Professional Psychology: Research and Practice, 22*, 161–170.
19. Vaillant GE (1992). The beginning of wisdom is never calling a patient borderline: or; The clinical management of immature defenses in the treatment of individuals with personality disorders. *Journal of Psychotherapy Practice and Research, 1*, 117–134.
20. Campbell TW (1992). Therapeutic relationships and iatrogenic outcomes: The blame-and-change maneuver in psychotherapy. *Psychotherapy, 29*, 474–480.
21. Zuckerman RL (1989). Iatrogenic factors in "managed" psychotherapy. *American Journal of Psychotherapy, 43*, 118–131.
22. Reis BF, Brown LG (1999). Reducing psychotherapy dropouts: Maximizing perspective convergence in the psychotherapy dyad. *Psychotherapy, 36*, 123–136.
23. Snyder CR, Shenkel RJ, & Schmidt A (1976). Effects of role perspective and client psychiatric history on locus of problem. *Journal of Consulting and Clinical Psychology, 44*, 467–472.
24. Shenkel RJ, Snyder CR, Batson CD, & Clark GM (1979). Effects of prior diagnostic information on clinicians' causal attributions of a client's problems. *Journal of Consulting and Clinical Psychology, 47*, 404–406.
25. Langer EJ, Abelson RP (1974). A patient by any other name. . .Clinician group differences in labeling bias. *Journal of Consulting and Clinical Psychology, 42*, 4–9.

26. Snyder CR (1977). "A patient by another name" revisited: Maladjustment or attributional locus of problem? *Journal of Consulting and Clinical Psychology, 45*, 101–103.

27. Batson CD, O'Quin K, & Pych V (1982). An attributional theory analysis of trained helpers' inferences about clients' needs. In T. A. Wills (Ed.), *Basic processes in helping relationships* (pp. 59–80). New York: Academic Press.

28. Furman B, Ahola T (1989). Adverse effects of psychotherapeutic beliefs: An application of attribution theory to the critical study of psychotherapy. *Family Systems Medicine, 7*, 183–195.

29. Farina A, Gliha D, Boudreau LA, et al. (1971). Mental illness and the impact of believing others know about it. *Journal of Abnormal Psychology, 77*, 1–5.

30. Goodyear RK, Parish TS (1978). Perceived attributes of the terms client, patient, and typical person. *Journal of Counseling Psychology, 25*, 356–358.

31. Lewis HB (1987). Shame: The "sleeper" in psychopathology. In H. B. Lewis (Ed.), *The role of shame in symptom formation* (pp. 1–28). Hillsdale, NJ: Lawrence Erlbaum Associates.

32. Link BG (1987). Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectation of rejection. *American Sociological Review, 52*, 96–112.

33. Parish TS, Grosdidier LM, & Emmerson GJ (1992). Psychiatrogenic effects of counseling: Self-concepts and the negative effects of labeling. *College Student Journal, 17*, 202–204.

34. Retzinger SM (1989). A theory of mental illness: Integrating social and emotional aspects. *Psychiatry, 52*, 325–335.

35. Scheff TJ (1974). The labeling theory of mental illness. *American Sociological Review, 39*, 444–452.

36. Bentz WK, Edgerton JW (1971). The consequences of labeling a person mentally ill. *Social Psychiatry, 6*, 29–33.

37. Link BG, Cullen FT, Struening E, et al. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review, 54*, 400–423.

38. Loman LA, Larkin WE (1976). Rejection of the mentally ill: An experiment in labeling. *The Sociological Quarterly, 17*, 555–560.

39. Arkar H, Eker D (1994). Effect of psychiatric labels on attitudes toward mental illness in a Turkish sample. *The International Journal of Social Psychology, 40*, 205–213.

40. Hillman J (1983). *Healing Fiction*. New York: Station Hill Press.

41. Logue MB, Sher KJ, & Frensch PA (1992). Purported characteristics of adult children of alcoholics: A possible "Barnum effect." *Professional Psychology: Research and Practice, 23*, 226–232.

42. Gough HG (1954). Some common misconceptions about neuroticism. *Journal of Consulting Psychology, 18*, 287–292.

43. Meehl PE (1973). *Psychodiagnosis: Selected Papers*. Minneapolis, MN: University of Minnesota Press.

44. Graziano AM, Fink RS (1973). Second-order effects in mental health treatment. *Journal of Consulting and Clinical Psychology, 40*, 356–364.

45. Adler HM, Hammett VB (1973). The doctor-patient relationship revisited: An analysis of the placebo effect. *Annals of Internal Medicine, 78*, 589–595.

46. Stricker, G (1995). Failures in psychotherapy. *Journal of Psychotherapy Integration, 5*, 91–93.

47. Christensen A, Jacobson NS (1994). Who (or what) can do psychotherapy: The status and challenge of nonprofessional therapies. *Psychological Science, 5*, 8–14.

48. Faust D, Zlotnick C (1995). Another dodo bird verdict? Revisiting the comparative effectiveness of professional and paraprofessional therapists. *Clinical Psychology and Psychotherapy, 2*, 157–167.

49. Strupp HH, Hadley SW (1979). Specific vs. nonspecific factors in psychotherapy. *Archives of General Psychiatry, 36*, 1125–1136.

50. Garfield SL (1994). Research on client variables in psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed.) (pp. 190–228). New York: John Wiley & Sons, Inc.

51. Talmon M (1990). *Single-session therapy: Maximizing the effect of the first (& often only) therapeutic encounter*. San Francisco, CA: Jossey-Bass.

52. Rosenbaum R (1994). Single session therapies: Intrinsic integration? *Journal of Psychotherapy Integration, 4*, 229–252.

53. Talmon M (1993). *Single session solutions*. Reading, MA: Addison-Wesley Publishing Company.

54. Arkes H (1981). Impediments to accurate clinical judgment and possible ways to minimize their impact. *Journal of Consulting and Clinical Psychology, 49*, 323–330.
55. Frances A, Clarkin JF (1981). No treatment as the prescription of choice. *Archives of General Psychiatry, 38*, 542–545.
56. Barnard C (1994). Resiliency: A shift in our perception? *American Journal of Family Therapy, 22*, 135–144.
57. Berg KI, De-Jong P (1996). Solution-building conversations: Co-constructing a sense of competence with clients. *Families in Society, 77*, 376–391.
58. Fish J (1996). Prevention, solution-focused therapy, and the illusion of mental disorders. *Applied and Preventive Psychology, 5*, 37–40.